



# Bnei Akiva Hachshara

## Medical Form

This form will be treated as confidential. Please complete the form with a black pen in block capitals. Use additional sheets if necessary.

First names \_\_\_\_\_ Family name \_\_\_\_\_

Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

Parents are:  married  divorced  separated  widowed

Full address \_\_\_\_\_

\_\_\_\_\_ Zip/post code \_\_\_\_\_

Country \_\_\_\_\_

Home phone \_\_\_\_\_

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_

Passport number \_\_\_\_\_ Expiry date \_\_\_\_\_

Person in Israel to notify in case of emergency:

Name \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

1.  Vegetarian  Vegan  Other dietary requirements \_\_\_\_\_

2. Height \_\_\_\_\_ Weight \_\_\_\_\_

3. Have you or any member of your family suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, or any other diseases?  Yes  No

If "yes", please give details: \_\_\_\_\_

4. Please list any hospitalizations and diagnoses: \_\_\_\_\_

\_\_\_\_\_

5. Have you ever received psychological counseling?  Yes  No

If "yes", please give details: \_\_\_\_\_

6. Are you allergic to any medications?  Yes  No

If "yes", please give details: \_\_\_\_\_

7. List any other allergies: \_\_\_\_\_

If your allergy may require special attention, please attach a letter to this medical form with full details.

8. Have you ever suffered from an eating disorder?  Yes  No

If "yes", please give details: \_\_\_\_\_

## MEDICAL EXAMINATION TO BE COMPLETED BY A PHYSICIAN

Full name: \_\_\_\_\_

	Normal (✓)	Deviation from normal
Vision		
Heart		
Lungs and chest		
Blood pressure		
Hernia		
Hemoglobin		
Abdomen and digestive tract		
Mouth and throat		
Skin		
Spine		
Feet		
Nervous system		
Allergies		
Menstrual history		

Other remarks: \_\_\_\_\_

Allergies: \_\_\_\_\_

Is the candidate presently receiving any medications?  Yes  No

If 'Yes', please attach statement of such medications with dosage and directions.

List any medication that the candidate has taken regularly at any point over the last three years:

\_\_\_\_\_

Has the candidate manifested any signs of an eating / dietary disorder?  Yes  No

Details: \_\_\_\_\_

Does the candidate have any physical limitations?  Yes  No

Details: \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

**I have examined the above named candidate and consider him/her physically and emotionally able to participate in your program in Israel.**

Name of physician (please print and stamp) \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

**To the best of my knowledge, all the above information is both accurate and complete.**

Candidate's signature \_\_\_\_\_